Washington State Department of Social & Health Services

STOP WORK

CSO/WORKER NAME	TELEPHONE NUMBER
CLIENT IDENTIFICATION NUMBER	DATE

Section 1: Fill out this section before taking it to your job that has ended.

By signing here, I give my permission to my employer to complete this form for the Department of Social and Health Services.

SIGNATURE	DATE	PLEASE PRINT YOUR NAME HERE

NAME OF COMPANY

COMPANY ADDRESS: STREET ADDRESS CITY STATE ZIP CODE

Section 2: The person in the company who knows the employment and pay information fills out this section.

1. What was the last date that the employee worked?_____

2. Amount of final paycheck (before taxes): $_____ Date received:_____

   List the amounts (before taxes) and dates received for other paychecks received in the same month as the final paycheck:

AMOUNT RECEIVED (BEFORE TAXES)	DATE RECEIVED
$_____	_____
$_____	_____
$_____	_____
$_____	_____

3. Why did this job end?

   ☐ Lack of work ☐ Job was temporary/seasonal ☐ Laid off

   ☐ On leave (such as leave of absence or maternity leave). Is it: ☐ Paid ☐ Unpaid

   If paid, how much is the employee paid: $_____

   When is the employee expected to return?_____

   ☐ Other:_____

4. Will the employee receive any severance pay? ☐ yes ☐ No

   IF YES: When will it be received?_____ How much will it be? $_____

5. Can the employee cash out vacation/sick pay? ☐ yes ☐ No

   IF YES: When will it be received?_____ How much will it be? $_____

6. Can the employee withdraw retirement/pension/401K funds? ☐ yes ☐ No

   IF YES: When will it be received?_____ How much will it be? $_____

Please provide the following in case we need to contact you:

SIGNATURE	DATE	TELEPHONE NUMBER
PRINT YOUR NAME HERE	POSITION/TITLE	